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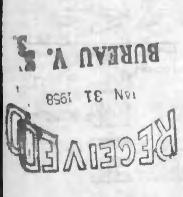
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1, 8	COUNTY 2	eau	au	MARY	2. USUAL RESIDEN Q. STATE	CE (Where deced	sed lived. If Institu b. COUNT		before adm	nission)
Ь	and give request town)	ech 74	write RURAL	c. LENGTH OF STAY	IN 1b c. CITY OR TOW	/N (If outside co	porale mins, write	RURAL and gi	ve neorest h	awn)
	I. NAME OF HOSPITAL	OR INSTITUTION	i (If nat in hospi	tal, give street addre	d STREET ADDR	ESS			ON	RESIDENCE A FARM
	NAME OF DECEASED (Type or print)		ary	Middle	Berry	4. DATE OF DEATH	James	2:	5	Year 19-58
3. S J	Forme	6. COLOR OR RAC	VIDOWED		8. DATE OF BIRTH	wee	9. AGE (in years last birthday)	Months Day		Min.
Oa.	USUAL OCCUPATION furing most of working	life, even if retire	rk done 10b. Kill d)	ND OF BUSINESS OR	INDUSTRY 11. BIRTHPLACE (State or foreign			L- S	COUNT
13.	FATHER'S NAME	30101	Lan /	Boroadu	TA. MOTHER'S MAIE	IEN NAME	nee	•		
15. (Yes,	WAS DECEASED EVER	IN U. S. ARMED		OCIAL SECURITY NO.	17. INFORMANT	Shake	-Address	Burn	is wi	w
			157	CZX	A INCOMMENTED			,		
				r (a), (b), and (c).]	any occlu	-		10	NTERVAL BETWO	/EEN
	PARY 1. DEATH IN IF Conditions, if any gave rise to immedia (a), stating the uncause last.	Enter only one WAS CAUSED BY IMEDIATE CAUSE DUE 1 , which te cause derlying DUE 1	(o) C (o) fb1	r (a), (b), and (c).	any occlu	aion		C	nterval betwo	/EEN
CATION	PARY 1. DEATH IN IF Conditions, if any gave rise to immedia (a), stating the uncause last.	Enter only one WAS CAUSED BY IMEDIATE CAUSE DUE 1 , which te cause derlying DUE 1	(o) C (o) fb1	r (a), (b), and (c).	70-1	aion		C	NITERVAL BETWO	AUTOPS
THEICAT	PARY 1. DEATH IN IF Conditions, if any gave rise to immedia (a), stating the uncause last.	Enter only one WAS CAUSED BY MEDIATE CAUSE DUE 1 , which the cause derlying R SIGNIFICANT CO	(c) C	(a), (b), and (c).	any occlu	TERMINAL DISEAS	SE CONDITION GIV	C	NITERVAL BETWO	/EEN
L CERTIFICAT	PART I. DEATH IN 14 2 0 . / Conditions, if any gave rise to immedia (a), storing the uncause last. PART II. OTHER 200. EXTERNAL CAUSE PRIMARY FOR CONT.	Enter only one WAS CAUSED BY MEDIATE CAUSE DUE 1 , which the cause derlying SIGNIFICANT CO	(c) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d	TRIBUTING TO DEATH	HBUT NOT RELATED TO THE T	FERMINAL DISEAS	SE CONDITION GIV	C	ONSET AND DE	AUTOPS
L CERTIFICATI	PARY I. DEATH IN 14 2 0 . / Conditions, if any gave rise to immedia (a), stoting the uncause last. PART II. OTHES 200. EXTERNAL CAUSE PRIMARY or CONTICAUSE OF DEATH. 20c. TIME OF INJURY Haur a. m., p. m.	Enter only one WAS CAUSED BY MEDIATE CAUSE DUE 1 , which to cause derlying R SIGNIFICANT CO WAS RIBUTING Month, Day,	(a) (b) (c) (c) (c) 20b. DESCRIBE P Year 20d. IN White (d) work (g) of the re	ITRIBUTING TO DEATH	H BUT NOT RELATED TO THE 1 RED. (Enter nature of injury in foctory, street, office bldg.) I above, held an Aut	Ferminal Diseas Port I or Port II form, 20f. (Cit. opsy, t	SE CONDITION GIV I of item 18.)	/EN IN PART 1(c	D) 19. WAS PERFO	AUTOPS ORMED? NO (State
L CERTIFICAT	PART I. DEATH Conditions, if any gave rise to immedia (a), stating the uncause lost. PART II. OTHES 200. EXTERNAL CAUSE PRIMARY ar CONTI CAUSE OF DEATH. 20c. TIME OF INJURY Hour a.m. p.m. 21. I certify tha	Enter only one WAS CAUSED BY MEDIATE CAUSE DUE 1 , which to cause derlying R SIGNIFICANT CO WAS RIBUTING Month, Day,	(a) (b) (c) (c) (c) 20b. DESCRIBE P Year 20d. IN White (d) work (g) of the re	TRIBUTING TO DEATH	H BUT NOT RELATED TO THE 1 RED. (Enter nature of injury in foctory, street, office bldg.) I above, held an Aut Suicide [], Homing M.D. CHIEF MEDIC.	FERMINAL DISEAS Port I or Port II form, 20f. (Cit opsy, t cide, U	se CONDITION GIV of item 18.) y or town) nspection [4]	/EN IN PART 1(c	o) 19. WAS PERFO	AUTOPS DRMED? NO [
L CERTIFICAT	PART I. DEATH IN 14 2 0 . / Conditions, if any gave rise to immedia (a), stating the uncause last. PART II. OTHER 20c. EXTERNAL CAUSE PRIMARY ar CONTI CAUSE OF DEATH. 20c. TIME OF INJURY Hour a.m. p. m. 21. I certify that death resulted for	Enter only one WAS CAUSED BY MEDIATE CAUSE DUE 1 , which to cause derlying R SIGNIFICANT CO WAS RIBUTING Month, Day,	(a) (b) (c) (c) (c) 20b. DESCRIBE P Year 20d. IN White (d) work (g) of the re	TRIBUTING TO DEATH	HBUT NOT RELATED TO THE 1 RED. (Enter nature of injury in factory, street, office bldg, dabove, held an Authorization of the factory, street, office bldg, dabove, held an Authorization of the factory, street, office bldg, dabove, held an Authorization of the factory, street, office bldg, dabove, held an Authorization of the factory, street, office bldg, dabove, held an Authorization of the factory of the fa	FERMINAL DISEAS Port or Port form, 20f. (Cit.) opsy	se CONDITION GIV of item 18.) y or town) inspection (4.)	/EN IN PART 1(c	o) 19. WAS PERFO	AUTOPORMED?

TO DEPUTY MEDICAL EXAMINER; This certificate should be executed within 24 hours after death. If any delay is necessary, please executed the certific function of the funeral director type 4 should be forwarded to the chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a buriof-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or near the contract of the cont

Vs. A15ME(5) 5M 9/\$5



1	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
g é	MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 11097
	1. PLACE OF DEATH a. COUNTY D. STATE MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) B. STATE B. COUNTY
28a buriol,	b. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) Church Hill R-F8 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) Church Hill R-FA
es. prior lo	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES \(\sum \) NO \(\sum \)
your fill	3. NAME OF DECEASED (Type or print) R-Middle G-650 4. DATE Month 25 1958
the formed for the formed for the formed for the formed formed for the formed f	5. SEX Jamele 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 1905 9. AGE IIn year lost birthday) Months Days Hours Min. Months Days Hours Min.
e retoil	100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY: 9. S. 12. CITIZEN OF WHAT COUNTRY:
S may b	13. FATHER'S NAME LONG. Know 20-20 14. MOTHER'S MAIDEN NAME LONG THE STATE OF THE S
Poge File pog	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If SOCIAL SECURITY NO. 17. INFORMANT Sub- Church Still P. 7
in Item 18. G with form PM3.	18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which } (b)
olong olong buria	gove rise to immediate couse (a), stating the underlying cause last. (c)
office sed os of	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19, WAS AUTOPSY PERFORMED? YES \(\text{NOT} \) NO \(\text{TL} \)
M be u	200. EXTERNAL CAUSE WAS PRIMARY OF OF DEATH. 200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port t or Port II of item 18.)
the war ical Exc 3 shou	20c, TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While Not while of work at work at work at work
Med	21. I certify that I took charge of the remains described above, held on Autopsy . Inspection . Inquiry . and find that
Seier S.	death resulted from: Natural causes 1. Accident . Suicide . Homicide . Undetermined cause .
SECT OF SECTION OF SEC	actual W. Derry Fisher DATE SIGNED
C Loring	SIGNATURE M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER 1/27-50
rworded FUNERAL FUNERAL	NAME (Type) DEPUTY MEDICAL EXAMINER (2)
or of FUI	270 BURIAL CREMATION, 226. DATE THEREOF STORM OF CEMETERY OF CREMATORY 22d. LOCATION (City, town, or county) (Store) Manual Co, Manu
rs. A15ME(S)	23. FUNIERAL DIRECTOR'S SIGNATURE APORESS 240. REGISTRAR 245- REGISTRAR'S SIGNATURE APORESS 240. REGISTRAR 245- REGISTRAR'S SIGNATURE

BUREAU V. E.

, 8561 IE NAI



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 **CERTIFICATE OF DEATH** Rea, Dist. No. director 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) filed o. COUNTY Queen Maryland b. COUNTY MARYLAND death. S.C b. CITY OR TOWN (If outside corporate limits, write C. LENGTH OF STAY IN 15 8 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) RURAL and give nearest town Chestertown Chestertown R. D. hours after d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS E. IS RESIDENCE OR INSTITUTION ON A FARM? near Kingstown Kingstown near YES NO 19 in bus NAME OF Middle 4. DATE Year Filled DECEASED HERBERT ELLSWORTH HOFFMAN Jan. (Type or print) DEATH 19 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 8. DATE OF BIRTH 9. AGE (In years lost byrthday) IF UNDER 1 YEAR IF UNDER 24 HRS Months Nov. 29 1910 WIDOWED T DIVORCED | popers. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? deoth. during most of working life, even if retired)
COntractor painting Cambden, N. J. U.S.A. Puo carbon ofter o 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician Herbert E. Hoffman Julia Eliz, Quinn remove 15. WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs.Lillias Hoffman Chestertown. Md. no ottending that the death 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH 3 hours ā Coronary thrombosis PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) 420.1 DUE TO É Coronary artery disease 6 months ony Conditions, if any, which been signed gave rise to immediate DUE TO couse (a), stoting the underoud lying couse lost. burial-transit physician PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? 0 YES NO ROK 20g. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Port II of item 18.) os the 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) Hour a. m. factory, street, office bldg., etc.) While Nat while al work at work p. m. January 14 21. I certify that I attended the deceased fram that I last saw the deceased 1. P.M., from the causes and on the date stated above. Jan.1 alive on and that death occurred at ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL Chestertown, Md. 9 prior A.C. Dick PHYSICIAN'S NAME (Type)

FUNERAL DIREC TO FUNERAL DIR

220. BURIAL, CREMATION, 226. DATE THEREOF

REMOVAL (Specify)

23. FUNERAL DIRECTOR'S SIGNATURE

Chestertown.

22c. NAME OF CEMETERY OR CREMATORY

Chester Cemetern

24a, REC'D BY REGISTRAR DATE JAN 2 11 '58

24b. REGISTRAR'S SIGNATURE

(State)

22d. LOCATION (City, town, or county)

Chestertown,

BUREAU V. R.

8961 08 NV+

SECEINED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 haurs after death. If any delay is necessary, please execute the certificate within 9 he word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 ta the funeral director cage 4 should be farwarded to the files. Additional Examiner's Office along with farm PM3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar priar to burial, cremation, or removal. **VS. A15ME(5)** SM 9/55

1105 MEDICAL EXAMINER	S CERTIFICATE OF DEATH Reg. Dist. No. (11)99
1. PLACE OF DEATH 2 COUNTY MARYLAN	2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE W. C. b. COUNTY Lucau Our
b. CITY OR TOWN (If ourside corporary limits, scite RURAL and give negret town) Low C. LENGTH OF STAY IN II	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS o. IS RESIDENCE on a FARM? YES \(\sum \) NO \(\sum \)
3. NAME OF DECEASED Tas First Win Middle &	voly IT DEATH Jack 22 1958
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	Africa 27-1956 Soil birhodayl yrs. Months Days Mours Min.
10c. USUAL OCCUPATION (Give kind of work dane) during most of working life, even if retired)	Pond Low Ast 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Jas William Lively	14. MOTHER'S MAIDEN NAME Marg aret Thuis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] [If yes, give wor or dotes of service] [If yes, give wor or dotes of service]	Mochine Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditions, if eny, which gove rise to immediate course (a), stating the underlying course lost. (c)	floor + was lung - white ADDUTH y a brain lesson
7 (0)	T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
	(Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, P Hour a, m. 19 While of work of work	LACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described at death resulted from: Natural causes . Accident . S ACTUAL SIGNATURE . The signature . Accident . S	Dove, held an Autopsy , Inspection , Inquiry , and find that uicide , Homicide , Undetermined cause . M.D. CHIEF MEDICAL EXAMINER
EXAMMER'E NAME (Type)	ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER
220. BURIAL, CREMATION, 27b. DATE THEREOF 22c. NAME OF CEMETERY CONTROL OF CEMETERY CO	SANT (1-1) POND TOWN, or county) (State) SANT (2-1) POND TOWN 240. REC'D BY REGISTRAR'S SIGNATURE DATE DATE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



TO HOSPITAL OF ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours leath. Page 4 may be retained the hospital or attending physician.

TO FUNERAL DIRE. At After this certificate has been signed by the attending physician and campletely filled in by no binector, page 3 should be detached for use as the burial-transit permit. Then please remark carbon papers. Pages 1 and 2 should be filed-with the registrar prior to burial, crematian, or removal, and in any event within 72 haurs offer death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01100

CERTIFICATE OF DEATH 1106 Rea. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived of institution, Residence before admission) a. COUNTY o. STATE **b.** COUNTY MARYLAND har ha d b CITY OR TOWN (If outside corporate limits, write c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporale limits, write RURAL and give nearest town) RURAL and give peprest town) Su M. marille lersville d. STREET ADDRESS d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION] - SVILLE IS RESIDENCE ON A FARM? Sudlersville YES NO DE NAME OF Middle 4. DATE Month Yeor DECEASED OF James Lduard Stavens DEATH (Type or print) 19 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED 9 AGE (In years 5. SEX B DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS Joss birthdoy) Sept. Months Days Hours Min WIDOWED T DIVORCED T 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stole or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) books 11.00 . 13. FATHER'S NAME 14_MOTHER'S MAIDEN NAME James Bramble Stevens Juliet Maria Hearn 15. WAS DECEASED EVER IN U. 5 ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (If yes, give war or dates of service) 21 c -03-3930 Lillie Belle Stevens, Sudlersvil no 1B. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL PETWEEN DNSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 420.1 DUE TO Conditions, if any, which gove rise to immediate DUE TO couse (o), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO CEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES TO NO D 206. ACCIDENT WAS UNDERLYING TO 206 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Polit I or Port II of Item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. YNJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or lown) (County) (Stote) foctory, street, office bldg , etc.) Hour a. n. While Not while of work at work o. m. 21. I certify that I attended the deceased from... T CUM Z, 19-2 Z, that I last saw the deceased and that death accurred at 63 07 M, from the causes and an the date stated above. alive an. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 220 BURIAL CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, fown, or county) (Stote) REMOVAL (Specify) Suarersville 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24o, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

SUTE OF STATES

01101 CERTIFICATE OF DEATH 1107 Rea, Dist. No. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived III institution, Residence before admission) o COUNTY b. COUNTY MARYLAND Marvland Queen Anne Queenanæe CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lawn) RURAL ond a ve regrest town) Centreville Centreville 4vrs. d. NAME OF HOSPITAL (If not in haspital, give street address)
OR INSTITUTION
63 RT-2 d. STREET ADDRESS of RESIDENCE ON A FARM? YES NO DO NAME OF 4. DATE First Middle Last Month Day Year DECEASED OF DEATH 15 William Edward Thomas (Type or print) Pages 19 6. COLOR OR RACE 7. MARRIED THEYER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 8. DATE OF BIRTH AGE (In years last birthday) Months Days Haurs Col Male DIVORCED [7] 68 WIDOWED | papers. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or fareign country) during most of working life, even if retired) 12 CITIZEN OF WHAT COUNTRY? REtired Maryland U.S.A. General Laborer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Martha A. Cephaus Iseral Thomas IS WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address (If yes, give war or dates of service) Centreville Mrs. Blanche Thomas 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH 10 PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) OX **DUE TO** omy Conditions, if ony, which gave rise to immediate **DUE TO** catte (a), stating the underlying couse lost. **burial-transit** PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO P 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part III of item 18.) 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) Hour o. m. While Not while at wark 🔲 at wark p. m. Jak 15 1938 that I lost sow the deceased 21. I certify that I offended the deceased from detoched and that death occurred at 139M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL è SIGNATURE 3 should PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREO! 22c. NAME OF CEMETERY OF CREMATORY 22d. LOCATION (City, town, or county) (State) page REMOVAL (Specify) a P Salem Centreville. Cemeterv Md. Burial PUNERAL DIRECTOR'S SIGNATURE 24g, REC'D BY REGISTRAR 200 REGISTRAR'S SIGNATURE ADDRESS PATE 14 2 3 '58 1SM 9/SS

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FUNERAL DIRECT

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Manna A T.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. No. (11102 **CERTIFICATE OF DEATH** 1108 I director, filled with 1. PLACE OF DEATH 2. USUAL RESIDENCE (Whyre deceased lived. If institution: Residence before admission) a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RBRAK and give nearest fown) c. LENGTH OF STAY IN 16 c. CITY_OR TOWN (If autside aproporate Jimits, write_RURAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS OR INSTITUTION ON A FARM? 20 YES NO .0 NAME OF Middle 4. DATE Month Year Day filled DEATH Pages (Type or print) 19 5 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years last bitthday) IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX B. DATE OF BIRTH e × Months Days Min. House DIVORCED [7] TE WIDOWED X сашріе YIS. papers. 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? deoth. during most of working life, even if mired) 5 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 16. SOCIAL SECURITY NO. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 17. INFORMANT Address 18. CAUSE OF DEATH [Enter only one cause pel line for lb), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH ā PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **DUE TO** permit. Conditions, if any, which any gave rise to immediate **DUE TO** casse (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(9) 19. WAS AUTOPSY PERFORMED? YES NO CERTIFI 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) matian, 20c. TIME OF INJURY Month. Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) Hour o. m. factory, street, affice bldg., etc.) While Not while at work wark p. m. 21. I certify that I attended the deceased from 19 5 . Hat I last saw the deceased alive on and that death accurred M, from the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED TO FUNERAL DIRECT Dage 3 should be do ACTUAL SIGNATURE PHYSICIAN'S NAME (Type the regit 220 BURIAL PREMATION. 22b. DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION (City Jown of county). (State) REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE A DORESS 24o. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE JAN 15M 9755

death.

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BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH cremation, Rea. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY O. STATE b. COUNTY A MARYLAND 1000 rial, b. CITY OR TOWN Iff autide corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN-(If outside corporate limits, write RURAL and give negrest town) trasouvelle asproulle d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO PO NAME OF Middle DATE -- Month Dov Year Your DECEASED DEATH Jane (Type or print) 19,58 5. SEX 6. COLOR OR RACE 7. MARRIED THEVER MARRIED 3. DATE OF BIRTH 9. AGE (In yours IFUNDER TYEAR IF UNDER 24 HRS. last birthday) Months Doys Houri Min. WIDOWED [7] DIVORCED [" Ca yrs. 11. BIRTHPLACE (Stote or foreign cyruntry) 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) mise 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME M 960 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN Address Give 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH celus PART !. DEATH WAS CAUSED BY: erouan IMMEDIATE CAUSE (O) DUE TO Conditions, if any, which gove rise to immediate couse burial **DUE TO** (o), stoting the underlying couse lost. Office PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(p) 19. WAS AUTOPSY 03 PERFORMED? NO DO 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) PRIMARY | or CONTRIBUTING CAUSE OF DEATH. should 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, form, 20f. (City or tawn) (County) (Stote) factory, street, office bldg., etc.) While Not while 0. m. of work of work p. m. 21. I certify that I taak charge of the remains described above, held an Autopsy [], Inspection Z Inquiry and find that to the left death resulted fram: Natural causes ... Accident , Suicide , Hamicide . Undetermined cause ACTUAL DATE SIGNED CHIEF MEDICAL EXAMINER SIGNATURE forworded to FUNERAL ASSISTANT MEDICAL EXAMINER EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER 220. BURIAL, CREMATION, 225 22c. NAME OF CEMETERY OR GREMATORY 22d, AOCATION (City, Iown, off county) 0 FUNERAL DIRECTOR'S SIGNATURE 240. REC'D BY REGISTRAR 245_ REGISTRAR'S SIGNATUR VS. A15ME(5) 5M 9/55

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BUREAU V. &

896! DI NO!